MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION SERVICES

OPERATIONAL STANDARDS

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I. INTRODUCTION

The Massachusetts Department of Public Health (MDPH) was designated lead agency for Part C (formerly known as Part H) of the Individuals with Disabilities Education Act in 1988. Operational Standards were developed based on Part H of Public Law 102-119, 34 CFR Part 303, Early Intervention Program for Infants and Toddlers with Disabilities, and Massachusetts General Laws, Chapter 111G.

The Massachusetts Early Intervention system is comprised of community-based programs certified as Early Intervention programs by the Massachusetts Department of Public Health. These programs provide comprehensive, integrated services, utilizing a family centered approach, to facilitate the developmental progress of eligible children between the ages of birth to three years old. Eligible children are those children who have a specific diagnosed condition or whose development is delayed, or who are at risk for developmental delays due to certain biological and/or environmental factors.

Early Intervention services are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development. Services are selected in collaboration with families, using an Individualized Family Service Plan, and are provided under the supervision of a Massachusetts Department of Public Health-certified Early Intervention program in partnership with families. Services and staff reflect the cultural, linguistic, and ethnic composition of the state and of the families served. Programs must demonstrate a commitment to respond to the diversity of families in their communities. Early Intervention services focus on the family unit, recognizing

the crucial influence of the child's daily environment on his or her growth and development. Therefore, Early Intervention staff deliver services in the context of family daily routines, working in partnership with individuals present in the child's natural environment. Early Intervention staff support and encourage the families' use of and access to community-based resources that will continue to support and enhance the child's development.

These standards were developed to describe requirements of community Early Intervention programs, and are used as criteria by the Massachusetts Department of Public Health for Early Intervention program certification. These standards, and all Massachusetts DPH-certified Early Intervention programs, incorporate in their practice the following core values:

1. RESPECT

Recognizing that each group of people has its own unique culture, and honoring the values and ways of each family's neighborhood, community, extended family, and individual unit.

2. INDIVIDUALIZATION

Tailoring supports and services with each family to its own unique needs and circumstances.

3. FAMILY-CENTEREDNESS

Basing decisions with each family on its own values, priorities, and routines.

4. COMMUNITY

Realizing that each family exists in the context of a greater community, and fostering those communities as resources for supports and services.

5. TEAM COLLABORATION

Working as equal partners with each family and with the people and service systems in a family's life.

6. LIFE-LONG LEARNING

Viewing early intervention supports and services as a first step on a journey for each child, family, and provider.

II. DEFINITIONS

Caregiver As used in these standards, a caregiver is a person in whose care a child may be temporarily placed, including, but not limited to, non-custodial relatives, baby-sitters, child care providers, and nannies.

Co-treatment visit A co-treatment visit is either a home visit or a center-based individual visit with two or more Early Intervention Specialists of different disciplines present. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment. One co-treatment of Early Intervention Specialists is allowed per month for an enrolled child. Consultative visits with specialty providers for children with low incidence conditions are not considered co-treatments.

Day As used in these standards, day means calendar days.

Due Process Due process refers to the regulations established by the Massachusetts Department of Public Health for community Early Intervention programs certified by the Department of Public Health with respect to notice of rights, informed consent, records and confidentiality, appeals and complaints.

Early Intervention Program An Early Intervention program is one that is formally certified by the Massachusetts Department of Public Health as a community Early Intervention program. It is in compliance with these standards set forth by the Massachusetts Department of Public Health.

Early Intervention Services

General Early Intervention Services are services that (1) are designed to meet the developmental needs of each eligible child and the needs of the family related to enhancing the child's development; (2) are selected in collaboration

with the family in conformity with the Individualized Family Service Plan; and (3) are provided by qualified personnel working with an Early Intervention program.

Types of Services

(A) Home Visit A face-to-face meeting at the enrolled child's home or a setting outside of the Early Intervention program's primary (lead) site with the enrolled child, the enrolled child's parent, or both, and an Early Intervention Specialist for the purpose of furthering the child's developmental progress. A home visit is provided for a scheduled period of time not to exceed two hours.

(B) Center Individual Visit (CV01) A visit provided in conjunction with an **EI-only Child Group**, identified on the IFSP as a Center Individual Visit provided as part of an EI-only Child Group. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

Center Individual Visit (CV02) A visit provided in conjunction with a community-based child group service **held at any DPH-approved site** and identified on the IFSP as a Center Individual Visit occurring within a Community Group setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

Center Individual Visit (CV03) A visit provided without child group participation and identified on the IFSP as a Center Individual Visit. This service **requires** appropriate clinical justification on the IFSP as to why outcomes cannot be achieved in a natural setting. A center individual visit is provided for a scheduled period of time not to exceed two hours.

(C) Child Focused Group A face-to-face meeting at a community-based site of a group of enrolled children (2 or more), facilitated or co-facilitated by at least one certified Early Intervention Specialist (as defined in these

standards) for the purpose of furthering the enrolled child's developmental progress. Child focused groups are provided for a scheduled period of time from one to two-and-one half-hours not more than two times weekly. A child-focused group must be identified on the child's IFSP.

Child-focused groups may be provided in any of three types of settings: lead, shared or participatory, as defined in these standards. Each type of setting is subject to DPH approval, as defined in Section XI., E of these standards. Adult/child ratios for child-focused groups are as follows:

1) **Lead site**, where the Early Intervention program is responsible for administration of both the program and the physical facility.

a. Children under 18 months of age must be accompanied by a parent or caregiver (as defined in these standards) for any center-based activity at a lead site. Parents/caregivers must remain on site but are not required to remain in the group with the children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staff person (can include interns, volunteers, EI assistants, or EI associates) for every two children under 18 months. If only one EI staff person is present, it must be the EI Specialist who facilitates or co-facilitates the group.

b. Children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staff person for every three children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

2) **Shared site**, where the Early Intervention program shares responsibility with a community site for program services but not for the administration of the physical facility.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any center-based activity at a shared site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staffperson for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staffperson for every three EI enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents/caregivers of community children are expected to attend the group then parents/caregivers of EI-enrolled children are also expected to attend. Attendance sheets must be maintained for all participants.

3) **Participatory site**, where Early Intervention staff and families join an ongoing activity in the community where the Early Intervention program does not have responsibility for either the program administration or the physical facility.

a. EI-enrolled children under 18 months of age must be accompanied by a parent/caregiver for any activity at a participatory site. Parents/caregivers must remain on site but are not required to remain in the group with children. When parents/caregivers are not in the group, the adult/child ratio must be at least one EI staffperson for every two EI-enrolled children under 18 months.

b. EI-enrolled children 18 months of age and over: When parents/caregivers are not present in the group or on site, the adult/child ratio must be at least one EI staffperson for every three EI-enrolled children over 18 months.

c. The expectation of adult participation is consistent across groups. For example, if parents of community children are expected to attend the

group then parents of EI-enrolled children are also expected to attend. Documentation of attendance may be requested of the site staff, and filed in the children's files with progress notes.

There are two types of Child Focused Groups**: (1) Community Child Group** and **(2) EI-Only Child Group**. Each type of group must follow the above ratios.

Community Child Group (CG02) is a group of two or more children designed to provide developmental opportunities for children ages birth to three, including children who are participating in group services as part of an Individualized Family Service Plan, and children who are not enrolled in Early Intervention. The purpose of the group is to enhance each child's development, and to provide opportunities for young children to come together. The Community Child Group supports the concept that Early Intervention services are most effective when provided in families' everyday routines and activities.

Community Child Groups are provided in locations where young children are welcome and typically spend time. Everyday places may include childcare settings, playgrounds, libraries, community centers, Early Intervention programs, or other neighborhood and community programs. This Child Group should be specified on the IFSP as a "Community Child Group."

EI-Only Child Group (CG01) A developmental group of two or more children where the only participants are children and families enrolled in EI. When a child participates in an EI-Only Child Group, the child's IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward group services in a community setting. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. Child group services should be specified on the IFSP as EI-Only child Group.

(D) Parent-focused Group A face-to-face meeting of a group of enrolled children's **parents** with an Early Intervention Specialist for the purpose of support and guidance. A parent-focused group (s) is provided for a regularly scheduled period of time not to exceed two hours per week. If more than one parent of a child attends a group, the reimbursement for one of the parents (or both if no other insurance coverage) may be from the Department of Public Health.
Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent-focused groups. These educational groups will have an evaluation component, reported in the program's annual report.
A group for other members of the enrolled child's family, including siblings, may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of the developmental needs of the enrolled child on family members.

(E) Screening Screening consists of a face-to-face meeting of a referred child and caregiver with an Early Intervention Specialist to discuss a child's potential participation in Early Intervention.
Screening in Early Intervention may or may not include the administration of a developmental screening tool and is limited to two working hours. An initial visit that provides a family with an opportunity to discuss program participation can be considered a screening visit. Families may receive a screening visit by more than one Early Intervention program. Families are informed of their right to a full assessment at the screening visit.

(F) Assessment Assessment means the ongoing procedures used by appropriate qualified personnel throughout the child's eligibility to identify (1) the child's unique strengths and needs; and (2) the resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child. Eligibility evaluations may take place as part of an assessment. When evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the child are determined by a multidisciplinary team. This

event is referred to as an evaluation and assessment. Assessment hours, including eligibility evaluation and IFSP development, are limited to ten billable hours per year.

Early Intervention Specialist An Early Intervention Specialist is an individual who meets the criteria specified in Section V., B of these standards and is certified by the Massachusetts Department of Public Health. The certification may be provisional, provisional with advanced standing, or full certification.

Eligible Children As used in these standards, eligible children means those children, birth to age three, who through a multidisciplined evaluation by a certified Early Intervention program are deemed eligible to receive Early Intervention services. Eligible children may receive EI services up to but not on their third birthday.

Eligibility evaluation An eligibility evaluation refers to procedures used by appropriately qualified personnel to determine a child's initial and continuing eligibility. The evaluation is performed at least annually except for those children determined eligible through clinical judgement. An eligibility evaluation may be part of a multidisciplinary assessment.

Individualized Family Service Plan (IFSP) An IFSP is a written plan for providing Early Intervention services to an eligible child and the child's family in accordance with federal regulations and the Massachusetts Department of Public Health Early Intervention Operational Standards, Section VII.

Intake Visit The intake visit is the initial face-to-face contact with the family and provides an opportunity for initial discussion with family members regarding potential participation in Early Intervention. An intake visit may be billed as a screening visit.

Low-incidence condition Low incidence refers to a diagnosis of blindness, visual impairment, deafness, hearing loss, deafblindness, autism, or Autism Spectrum Disorder (ASD). A child who has one or more of these conditions fits the criteria for services to children with low incidence conditions.

Multidisciplinary team A team consisting of two or more Early Intervention Specialists of different disciplines, as defined in Section V. of these standards.

Primary language Primary language means the language or mode of communication normally used by the parent of a child seeking or using services. If the parent has a vision or hearing loss, the mode of communication shall be that normally used by the parent, such as sign language, Braille, oral communication or other appropriate mode of communication.

Natural Settings Natural settings are those settings that are typical for children similar in age who have no disabilities.

Parent As used in these standards, parent means the biological/adoptive parent of the child, legal guardian, other person having legal custody of the child, relative or close friend with whom the child lives and who takes responsibility for the child's welfare, or a surrogate parent, but does not include any parent whose legal right to make educational decisions has been terminated.

Parental Consent This term means that (1) the parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's primary language or other mode of communication; (2) the parent understands and agrees in writing to the carrying out of the activity for which consent is sought and the consent describes that activity and lists the records (if any) that will be released and to whom; and (3) the parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

Service Coordination As used in these standards, service coordination means the activities carried out by a service coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the state's Early Intervention system.

Specialty Provider A specialty provider is a professional who is specifically trained and/or credentialed in working with children with low incidence conditions and their families.

Surrogate Parent A surrogate parent is an individual assigned by the Massachusetts Department of Public Health to represent the rights of an eligible child in the following circumstances: (1) when the Department, after reasonable efforts, is unable to identify or locate the parent, guardian or person acting as parent of the child; or (2) when the child is in the legal custody of a State agency and the natural parent's rights to participate in educational decision making have been terminated. In this case, a foster parent will be designated as surrogate unless he or she indicates or demonstrates an unwillingness or inability to serve as surrogate.

Written informed consent This term means a form or other written record which serves as evidence that the explanation required for informed consent has been provided. The parent's signature shall serve as documentation that the parent understands and agrees to the proposed terms and activities.

III. Eligibility for Early Intervention Services

A. Determination of Eligibility

Certified Early Intervention programs determine eligibility for Early Intervention services through an eligibility evaluation performed by a multidisciplinary team, exercising sound clinical judgment, and using a developmental evaluation tool approved by the Massachusetts Department of Public Health.

B. Categories and Criteria of Eligibility

There are two categories of eligibility for early intervention services.

1. Children with Established Risk or Established Developmental Delays :

   This category includes (1) children whose early development is influenced by diagnosed medical disorders of known etiology bearing relatively well known expectations for developmental outcome within varying ranges of developmental delay and (2) children who, during the infancy period, or more commonly in the second year of life, begin to manifest developmental delays or deviations, often of unknown etiology.

   Criteria

   (1) The child has a known disabling physical or mental condition including but not limited to any of these diagnoses:

   - chromosomal abnormality
   - neurological condition
   - metabolic disorder
   - visual impairments not corrected by medical intervention or prosthesis, or
   - permanent hearing loss of any degree

   or

   (2) The child exhibits a delay* in one or more areas of development, including cognitive development, physical development including vision

and hearing, communication development, social or emotional development, or adaptive development

or

(3) The child has questionable quality of developmental skills and functioning based on the clinical judgment of a multidisciplinary team. A child found eligible based on clinical judgment can receive services for up to 6 months. For services to continue after this period, eligibility must be determined based on diagnosis, developmental delay or risk factors.

***Guideline: Developmental delay by age and months of delay**

AGE	**DELAY**
6 months or less	**1.5 months**
7-12 months	**3 months**
13-18 months	**4 months**
19-36 months	**6 months**

2. Children at Risk for Developmental Delays or Disorders: This category includes

(1) children with a history of prenatal, perinatal, neonatal, or early life events suggestive of biological insults to the developing central nervous system which, either singularly or collectively, increase the probability of later atypical development and (2) children who are biologically sound but whose early life experience, including maternal and family care, health care, nutrition, opportunities for expression of adaptive behaviors, and patterns of physical and social stimulation are sufficiently limiting to the extent that they impart high probability for delayed development.

Criteria

Four or more of the following risk factors are present:

CHILD CHARACTERISTICS

- Birthweight is less than 1200 grams (2 pounds 10½ ounces)
- Gestational age is less than 32 weeks
- NICU admission is more than 5 days
- Apgar score is less than 5 @ 5 minutes
- Total hospital stay is more than 25 days in 6 months
- Diagnosis of Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA)
- Weight for age, or weight for height, is below the 5th percentile; weight for age dropped more than 2 major centiles in 3 months in a child who is under 12 months of age or has dropped more than 2 major centiles in 6 months in a child who is 12 to 24 months of age.
- Chronic feeding difficulties
- Insecure attachment/interactional difficulties
- Blood lead levels measured at 15 µg/dl (micrograms per deciliter) or more.
- Suspected Central Nervous System abnormality
- Multiple trauma or losses

FAMILY CHARACTERISTICS

- Maternal age at child's birth is less than 17 years or maternal history of 3 or more births before age 20
- Maternal education is less than or equal to 10 years
- Parental chronic illness or disability affecting caregiving ability
- Family lacking social supports
- Inadequate food, shelter, or clothing
- Open or confirmed protective service investigation
- Substance abuse in the home
- Domestic violence in the home.

Appendix A of these standards provides explanations of eligibility criteria.

IV. Service Area

A. Local Service Area

An Early Intervention program serves all cities and towns within its service area as approved by the Department of Public Health. If more than one EI program shares a service area or a family is referred to an EI program outside the service area of the family's residence, upon referral to a program, parents are notified of the names of the other programs serving that service area and have the opportunity to talk with the other programs before having an eligibility evaluation. At the initial visit each family will be provided information about the *Massachusetts Early Intervention Program Guide* which contains the statewide listings of all Early Intervention programs.

B. Options

Parents are made aware that they may only enroll in one Early Intervention program. Once the family makes the choice, the program has 45 days to evaluate the child, determine eligibility and hold a meeting to discuss the Individualized Family Service Plan (IFSP). Parents are also informed that investigating other programs may prolong the time it takes to complete the IFSP process. This discussion is documented in the intake file.

C. Out of Catchment Services

Programs are responsible for providing individualized services to families as outlined in the IFSP. Occasionally this means that services may be provided outside of the service area in which the family resides.

The Regional Early Intervention Specialist must be notified in writing of families not residing in the program's service area being served by the program. (See Out of Catchment Notification Form in the *Massachusetts Early Intervention Services Policy Book*).

V. Service Providers and Roles

A. Professional Certification

All professional staff members who will be providing direct service to children and families, employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract), are certified as Early Intervention Specialists by the Massachusetts Department of Public Health prior to billing for Early Intervention services.

Primary program administrators, usually Program Director or Program Coordinator, meet the credentialing requirements for one of the disciplines listed in Section B below. The primary program administrator is required to apply for Early Intervention Program Director certification within three years of hire to that position. Further description may be found in Section XII, Program Administration, of these standards.

Certification for Early Intervention Specialists may be:

a. Provisional (granted through the Department of Public Health to staff who meet entry level requirements and work in EI)
b. Provisional with advanced standing (granted through the Department of Public Health to graduates of DPH-approved higher education programs in early intervention after satisfactory review of completed application and transcripts) or
c. Full certification (granted through the Department of Public Health after satisfactory completion of the EI certification process. Application must be completed by the end of 3 years of employment at an MDPH-certified EI program, working at a minimum of 20 hours per week. Also granted to

graduates of DPH-approved higher education programs upon completion of 1440 hours of employment at an MDPH-certified EI program.)

B. Early Intervention Credentials

MDPH-certified EI programs must demonstrate a commitment to respond to the diversity of families in their communities. Staff should, to the extent possible, reflect the cultural, ethnic and linguistic background of families served.
The following are the minimum credentials for entry level provisional certification as an Early Intervention Specialist:

1. *As Developmental Specialist:*
    a) A bachelor's degree from an accredited institution with a major or concentration in infants and toddlers (includes early intervention and early childhood education), and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    b) A bachelor's degree from an accredited institution with a major or concentration in child development or child studies, and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    c) A bachelor's degree from an accredited institution with a major or concentration in education or special education, and at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

    d) A bachelor's degree from an accredited institution, with at least 300 hours of practicum or work experience with young children. Experience with infants, toddlers and families is preferred.

For a, b, c, and d transcripts of degree work or subsequent transcripts must reflect successful completion of at least 4 approved three-credit courses that focus on infants, toddlers, and families.

2. *In Nursing:* Current licensure as a registered nurse by the Massachusetts Board of Registration, Division of Professional Licensure, with either:

(a) A bachelor's degree in nursing from an accredited program, or

(b) An associate degree or diploma in nursing from an accredited institution and at least two years of experience in community-based services for infants, toddlers and their families.

3. *In Occupational Therapy*: Current licensure as an Occupational Therapist by the Massachusetts Board of Registration of Allied Health Professions.
4. *In Physical Therapy*: Current licensure as a Physical Therapist by the Massachusetts Board of Registration of Allied Health Professions.
5. *In Social Work*: Current licensure as a Licensed Clinical Social Worker (LCSW) or as a Licensed Independent Clinical Social Worker (LICSW) by the Massachusetts Registry of Social Work.
6. *In Psychology:* A master's degree from an accredited institution in
    (a) counseling psychology
    (b) clinical psychology
    (c) developmental psychology
    (d) educational psychology

    or

    (e) Current licensure as a Licensed Mental Health Counselor (LMHC) by the Massachusetts Board of Allied Mental Health and Human Services Professions

    (f) Current licensure as a Licensed Marriage and Family Therapist (LMFT) by the Massachusetts Board of Allied Mental Health and Human Services Professions
7. *In Speech and Language Pathology:* (a) Current licensure by the Massachusetts Board of Registration in Speech-Language Pathology and Audiology and a Certificate of Clinical Competence (CCC) granted by the

American Speech, Language and Hearing Association or (b) currently in clinical fellowship year prior to being granted a CCC.

Specialty Provider: Early Intervention services may also be provided by qualified personnel who bring specific expertise necessary for working with populations including, but not limited to, children with low incidence conditions and their families. Qualification is based on the highest requirements in the State applicable to the profession or discipline in which a person is providing early intervention services. To provide direct service to children and families, Specialty Providers are granted limited provisional certification as Early Intervention Specialists.

- The following are the minimum credentials for entry level provisional certification with advanced standing as an Early Intervention Specialist:

1. Graduation from a DPH-approved higher education Early Intervention training program. Upon graduation, Provisional Certification with Advanced Standing (PCAS) will be granted for up to three years.

- The following are the minimum credentials for full certification as a certified Early Intervention Specialist:

1. Submission of a portfolio documenting competencies as an Early Intervention Specialist within 3 years of employment (working at least 20 hours per week) in a MDPH-certified Early Intervention program, for staff with provisional certification, or
2. Completion of 1440 hours of supervised experience in a MDPH-certified Early Intervention program, for staff with provisional certification with advanced standing.

C. Related Credentials:

1. Early Intervention Assistant

   Early Intervention Assistant is an entry-level position with an educational requirement of a high school diploma or equivalent. The duties of these individuals are generally (1) organizational in nature, e.g. purchase of

materials or coordination of transportation; (2) related to child-focused groups, such as classroom preparation and/or (3) supervised participation in activities with children and families.

2. Early Intervention Associate

The Early Intervention Associate has a minimum educational requirement of a high school diploma or equivalent with additional credentialing working with infants and toddlers. An EI Associate may have any of the following credentials:

(1) Completion of an associate degree in Early Childhood Education
(2) Credentialing as a Child Development Associate
(3) Registration and licensure in Massachusetts as a Certified Occupational Therapy Assistant or a Physical Therapy Assistant
(4) Designation as a Lead Infant/Toddler Teacher by Office of Child Care Services
(5) Licensure in Massachusetts as a Licensed Practical Nurse
(6) Parent of a child enrolled for at least one year in a DPH-certified Early Intervention program

The scope of participation of an Early Intervention Associate includes work with children and families, under close and regular supervision and in accordance with the appropriate guidelines of practice for specific disciplines. Duties may include direct services to a child and family, participation in IFSP development, service coordination, program outreach, and intakes, all under the supervision of an Early Intervention Specialist.

Early Intervention Assistants and Early Intervention Associates do not bill for Early Intervention services.

D. Early Intervention Program Core Team

1. An Early Intervention Program has a minimum of three core team members, each of whom must work at least 30 hours per week. The core team is comprised of a Developmental Specialist (a through c) and two other professionals representing different disciplines as defined in B, 2 – 7 of this section. In addition to the core team, an Early Intervention program will have a full time director/coordinator.

2. If at any time following the initial program certification, the staffing of the program does not meet the requirements for a core team, the program director will notify the Regional Early Intervention Specialist in writing of the absence of a core team. The program will be given sixty days from the first day of noncompliance to regain compliance of this requirement. Families enrolled in the program will be notified in writing of the absence of a core team for the timeframe this situation exists and of the options available to them for comprehensive Early Intervention services. Families will also be given a copy of Family Rights in Early Intervention at this time. A copy of the written notice to families will be submitted to the Regional Early Intervention Specialist for review before distribution and a copy of the notification filed in each child's record. If a core team is not in place at the end of the sixty-day period, a program certification review will take place.

VI. Entry Into Program

A. Child Find

Child Find is a series of activities in the community that are organized to locate children and families who are potentially eligible for Early Intervention services and may be part of the EI program's community education activities. These activities may be initiated and carried out, with written parental permission, by EI program staff alone, in conjunction with staff of other agencies, or by other agencies without Early Intervention program involvement. If children and families are considered potentially eligible for EI services, on the basis of screening or less formalized developmental review, a referral to the EI program will be made according to the procedures described below.

B. Referral

1. EI programs accept referrals from all sources. If the family is not the referral source, they must be informed prior to referral. A face-to-face or telephone response to the family from the EI program is made within 10 working days following the initial referral. Attempts to contact families are documented in the child's record.
2. The EI program schedules a visit with the family preceded by written notification of what the visit will involve. Written parental consent is obtained at the first face-to-face contact in order for the visit to proceed.
3. Once the visit has been scheduled, the EI program shall assign a service coordinator to be available to the family during the eligibility determination and IFSP process. Within 45 days after receiving a referral, the Early Intervention program will complete the evaluation and assessment activities and, if the child is found eligible for Early Intervention services, hold a meeting to complete the IFSP process.

C. Screening/Intake Process

1. The initial face-to-face contact with the family provides an opportunity for discussion with family members regarding potential participation in Early Intervention. The visit is scheduled in response to family need with regard to time and location. Often the child's medical and developmental histories are discussed, an overview of Early Intervention is given to the family, and plans are made for the evaluation and assessment process. This visit may be billed as a screening visit. Families are informed of their right to a full assessment at the screening visit.
2. The parent is given the Massachusetts Department of Public Health Notice of Family Rights. The program will ensure that the parent understands the notice, that there is written evidence that these requirements have been met, and that the parent has been given the opportunity to discuss the contents of the notice and have questions answered.

D. Eligibility Evaluation

1. Eligibility evaluation means the procedures used by qualified personnel to determine a child's initial and continuing eligibility in Early Intervention. Eligibility evaluations are performed by certified Early Intervention programs.
2. Written parental consent is obtained prior to an eligibility evaluation.
3. As a part of this process, an evaluation of the child's development is to be made by a multidisciplinary team using a DPH-approved developmental evaluation tool. Functioning in each of the following areas is evaluated to determine eligibility:
    a. Cognitive development
    b. Physical development (gross and fine motor), including vision, hearing, and health status
    c. Communication development, including expressive and receptive language development

d. Social and emotional development

e. Adaptive development/self help

4. Eligibility evaluation further consists of a determination of family and child risk factors to document eligibility as described in Section III B.2. of these standards.
5. The eligibility evaluation process is culturally and linguistically appropriate for the child and family.
6. The disciplines represented on the multidisciplinary evaluation team are determined by the developmental areas of concern for the child.
7. When eligibility evaluation and assessment take place simultaneously, both eligibility and the strengths and needs of the child are determined by a multidisciplinary team. This event is referred to as an evaluation and assessment.
8. The primary referral source is notified in writing of the outcome of the eligibility evaluation with family consent.

E. Assessment

1. Assessment consists of those on-going procedures used by appropriate qualified personnel throughout the period of a child's eligibility for services to identify (1) the child's unique strengths and needs and the services appropriate to meet those needs; and (2) the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler.
2. The assessment emphasizes the collaborative process among Early Intervention personnel, the family, and other agencies and providers. Logistics should be primarily responsive to family and child needs and preferences regarding time, place and other such factors. Families will be given prior written notice of assessments. The notice will include the voluntary nature of consent.

3. A review of available records related to the child's current health status and medical history is to be completed as part of the assessment.
4. An assessment of family resources, priorities, and concerns is family-directed and designed to determine ways to enhance the development of the child. Any assessment of a family's need for support or services is voluntary in nature, and based on information provided by the family through personal interviews conducted by personnel trained in appropriate methods and procedures.

VII. Individualized Family Service Plan Development

A. An Individualized Family Service Plan (IFSP) is a working document produced collaboratively by program staff and family members that contains the agreed upon Early Intervention services for an eligible child and family. Based on multidisciplinary assessment, the plan includes services necessary to enhance the development of an eligible child, and the capacity of the family to meet the child's needs. The plan is written in the family's primary or chosen language, unless it is clearly not feasible to do so. An English translation of the child's developmental profile and the service delivery plan is available at the program site for coordination and program monitoring purposes. All certified Early Intervention programs use the IFSP form approved by the Massachusetts Department of Public Health.

B. The contents of the IFSP are fully explained to the child's family and informed written consent from the parents is obtained prior to the provision of Early Intervention services described in the plan. If the parents do not provide consent with respect to a particular EI service or withdraw consent after first providing it, that service may not be provided. ***This action will not jeopardize the provision of other Early Intervention services.*** The EI services to which parental consent is obtained must be provided.

C. An IFSP meeting is held with eligible families within forty-five days of referral. An IFSP meeting is convened at a time and place mutually convenient for the family and team members for the purpose of developing the plan. The Department of Public Health strongly discourages the practice of screening, evaluation and IFSP development on the same day. Written confirmation of IFSP meeting arrangements is sent to participants early enough to ensure attendance. Each initial and subsequent IFSP meeting, following an eligibility evaluation, includes the following participants:

1. The parent or parents of the child (or person legally designated in this function)
2. The individual designated to be the service coordinator
3. Another person or persons directly involved in conducting the evaluation and assessment
4. Other family or team members as requested by the parent if feasible to do so *
5. An advocate or other non-family member, if the parent requests that the person participate *
6. As appropriate, persons who will be providing services to the child and/or family

* If a person the parent wishes to have involved in the planning meeting is unable to attend, arrangements are made for the person's involvement through other means, including:

1. Participating in a telephone conference call
2. Having a knowledgeable designate attend the meeting
3. Making pertinent records available at the meeting

D. The plan is based on the results of multidisciplinary team assessment, and includes the following:

1. A statement of the child's present level of physical development (including vision, hearing, and health status), cognitive development, communication development, social and emotional development, and self-help/adaptive development. These statements are based on professionally acceptable objective criteria.
2. A statement of the child's strengths and needs, including documentation of the techniques used to determine the strengths and needs
3. Information regarding the child's and family's daily routines/activities
4. A statement of the family's strengths, concerns, priorities and resources related to enhancing the development of the child, if the family so desires

5. A statement of the outcomes identified by the family expected to be achieved for the child and family. The team, which includes the family, identifies the strategies to be focused on which include the criteria, procedures and timelines used to determine (1) the degree to which progress toward achieving the outcomes is being made; and (2) whether modifications or revisions of the outcomes or services are necessary
6. A statement of the Early Intervention services necessary to meet the unique needs of the child and family to achieve the outcomes, including transportation plans, service frequency (how often), duration (how long), and the location (where occurring) of sessions; whether these are individual or group services (method), and the EI staff member(s) responsible
7. A statement of the natural settings in which Early Intervention will be provided, including justification of the extent to which the services will not be provided in a natural environment
8. A statement of medical services, specialty providers and other community resources and services which are or will be involved with the child and family, with parental consent, including the Early Intervention program's plan for coordination with these resources
9. The time period covered by the plan, including the projected date of initiation of services as soon as possible after the IFSP meeting. Parents are kept informed of all efforts to secure services and documentation should reflect the search for services and methods used to obtain them. The date of parental signature shall constitute the initiation of the plan, with an expiration date not more than one year from initial parental signature.
10. The plan for service coordination agreed upon with the family, including the individual responsible for ensuring the coordination and implementation of the IFSP. This individual should be from the profession most relevant to the child or family's needs.
11. A statement of transition procedures

12. At least six months before anticipated discharge, the plan for transition either to services provided by the Local Educational Agency (LEA) or to other appropriate settings. This process follows the steps outlined in the Interagency Policy on Early Childhood Transitions. See Appendix B of these standards.

The IFSP must identify medical and other community services and resources that the child needs but that are not required under Part C of IDEA (Individuals with Disabilities Education Act) or M.G.L. 111G. The IFSP should also identify the steps that will be undertaken to secure those services through public or private resources.

E. At least every six months or whenever the family or another IFSP team member requests, the IFSP is reviewed by family and other team members. This review is to take place in a meeting or other means acceptable to the family and other participants. The review includes a determination of the degree to which progress is being made toward achieving agreed upon outcomes, appropriateness of services being delivered and/or possible changes in outcomes or service plan. These are documented on the corresponding page of the IFSP.

F. Modification of the IFSP may occur at any time. Modification may include changes in

- the outcomes
- specific Early Intervention services
- service frequency or location. Parental consent to any change is documented in writing on the IFSP before a change is made.
- information the parent chooses to have amended for any reason

G. At least annually, a multidisciplinary eligibility evaluation/assessment is performed and a meeting is held to revise the IFSP as appropriate, based on eligibility evaluation/assessment results.

H. Parents must be provided with a copy of their family's IFSP, including each revision.

VIII. Early Intervention Services

A. Children and families receive individualized services, in accordance with the outcomes identified in the IFSP. A range of options, provided at lead, shared or participatory sites, including home visits, center-based individual visits, parent/child groups, child-focused groups, parent-focused groups and services of specialty providers is available to all families. Intervention is designed to include the child, staff member(s) and parent or designated caregiver. The parent is encouraged to participate in services. If family circumstances preclude such participation, this is documented in the child's record and alternative communication strategies developed.

B. Services are available on a twelve-month basis. Any scheduled interruptions of any service for more than three (3) consecutive weeks are discussed and approved by the family, and documented on the Individualized Family Service Plan. Varying family needs and cultural differences are respected in the provision of Early Intervention services, and programs are responsive to family schedules if at all feasible.

C. Services are provided in the natural settings for the child, as determined through the IFSP process. Natural settings may include the child's home, childcare centers, family childcare homes, and other community settings.

D. The individual who will act as service coordinator is determined during the IFSP process. Service coordinator functions include the following:

1. Identify and negotiate service coordination functions with the family
2. Explain the IFSP process and procedural safeguards, and facilitate and participate in its development, review and evaluation
3. Collaborate with the family in identifying their strengths, concerns, priorities and resources

4. Facilitate the timely delivery of services
5. Coordinate and monitor evaluations, assessments, and service delivery, including the need for specialized assessments
6. Provide information on parenting issues and community resources
7. Educate and/or support the family in advocating for their rights and needs, including the availability of advocacy
8. Coordinate services with medical and health providers, with family consent
9. Refer to other case management systems when appropriate and with written parental consent
10. Assist in developing a transition plan
11. Refer the family to specialty providers as appropriate

IX. Transition and Discharge

A. The program will discharge a child and family from Early Intervention services when:

1. The child reaches his or her third birthday
2. The child and family no longer meet eligibility criteria
3. The family withdraws consent for all services. This is documented in the child's record.
4. The program is unable to contact/locate the child and family after reasonable attempts to contact and after a written notice has been sent to the family. This is documented in the child's record.
5. The child dies. The program may provide support to the family during the initial grieving process, with a waiver from the Department of Public Health.

B. The discharge date of all children is on or before the child's third birthday. Eligible children may receive services up to but not on their third birthday. To allow for collaboration and follow-up to occur, one visit within 90 days of the discharge date is allowed by the Department of Public Health. This visit may be a visit to the family, Local Education Agency (LEA) team meeting, or to the receiving program. This visit is recorded as a home visit.

C. Transition Plans must be developed for all children**.** Transition is the process by which a child and family are assisted in preparing for discharge from Early Intervention services. All information shared outside of the team requires parental consent. Transition plans are developed:

1. When the family moves from one Early Intervention program to another. Staff from the sending program and the family determine the steps to be taken to facilitate a smooth transition, and the individual(s) responsible for

each task. Staff from the receiving program, with parental consent, review the existing IFSP, including the assessment history**,** with the family and complete any agreed upon changes within forty-five days of the family's relocation. Disruptions of Early Intervention services to the child and family must be minimized, as much as possible.

2. At least six months before the child's 3rd birthday, a referral must be made to the LEA for possible services in accordance with MA Special Education Regulations (603 CMR 28.00, section 2804 (1) (d). The Interagency Policy on Early Childhood Transitions (found in Appendix B of these standards) includes the guidance for the planning process which will take place when the child is transitioning to special education services. At least 90 days before the child's 3rd birthday, with parental consent, the Early Intervention program convenes a meeting with the family, a representative from the LEA and the Early Intervention program staff**.** The purpose of this meeting is to review the child's service history, discuss possible program options with the LEA, and establish a transition plan. With parental consent, information about the child, including evaluation and assessment information and relevant information from the IFSP is sent to the LEA or other designated service provider or program.
3. When a child is determined ineligible for or has not been referred to preschool services under MA Special Education Regulations. With parental approval, the EI program makes reasonable efforts to convene a conference that includes the family and providers of other appropriate services for children (e.g., child care, Head Start, MA Family Networks, Community Partnerships for Children) to discuss appropriate services for which the child may be eligible.
4. When the child is under three years of age and either no longer meets the eligibility criteria for Early Intervention or the family chooses to terminate EI services. The reason for transition must be clearly documented in the child's record. Transition plans for children who are no longer eligible for EI services are in effect for up to forty-five days following the

determination of ineligibility, at which time the child is discharged from the EI program. There is documentation in the child's record of mutual agreement of determination of ineligibility.

X. Family Participation

A. Early Intervention in Massachusetts is a family-centered system. EI services are provided in a collaborative manner with families and EI service providers working as partners. Family members are encouraged to be active participants in every component of the Early Intervention service system. On an individual level family members are involved in determining and participating in services for their child and family. On the program level, families are encouraged to advise and participate in the development and monitoring of policies, procedures and practices. Family members may choose to participate in these advisory functions as a group or as individuals.

B. To ensure comprehensive family participation, all members of the EI service team share responsibility for providing an environment in which such participation can occur. Early Intervention programs provide multiple and varied opportunities for family participation that ensure responsiveness to the diverse needs and interests of the families in the service population and enhance the collaborative nature of service delivery.

C. In order to support family participation throughout the Early Intervention system, a program shall be able to demonstrate its efforts in the following activities:

1. Ensure that families understand the core values (see Section I of these standards) and range of individualized options, service delivery and supports
2. Establish a mechanism to share information about services, supports and opportunities with all families on a regular basis, not only on the first visit
3. Develop ongoing mechanisms which seek input from a diverse and representative number of families and incorporate the mechanisms into its policy and procedure/operations manual as part of its administrative organizational plan

4. Ensure that all families are aware of the existence of and have access to the program's policy/procedure/operations manual. The program will assume the cost of copying specific policies on request.
5. Ensure that a diverse and representative number of families are involved in the annual self evaluation which should include areas such as:
    a. Feedback on staff performance
    b. Evaluation of program services
    c. Review of the IFSP process
    d. Approaches to family participation
    e. Review of transition procedures
6. Programs will respond to written suggestions and evaluations offered by families within 7 days. Families who have difficulty in producing written documentation may request assistance.
7. Families and program staff will work together to develop an action plan to address concerns.
8. Include a diverse and representative number of families in any ongoing program development initiatives, such as the development of goals and objectives for the annual plan, service delivery task groups, modifications/updates to the policies and procedures, etc.
9. Develop mechanisms to share information about the EI statewide system and opportunities for parent participation including but not limited to the following:
    - making the Parent Leadership Project Resources Manual available to families
    - distributing *Parent Perspective* newsletter during home visits
    - inviting a parent to accompany EI staff to an ICC (Interagency Coordinating Council) related activity
    - sponsoring a parent to attend the MEIC (Massachusetts Early Intervention Consortium) Conference
    - informing families of statewide trainings
    - encouraging family participation on working committees

D. To assist in the above efforts, the program shall:

1. Designate an EI staff member to facilitate the involvement of a diverse and representative number of families and serve as a link between the staff and families
2. Cover reasonable administrative expenses such as copying and distribution of information requested by families
3. Recruit and support a parent currently receiving EI services to be the contact person for the EI Parent Leadership Project; this parent contact will share information among the Parent Leadership Project, program staff and families enrolled in the program.
4. Notify the Parent Leadership Project of the names of both the designated EI staff member and the current parent contact by calling 1-877-35-EI-PLP.
5. Invite the regional Parent Leadership Project Coordinator to attend at least one EI staff meeting annually.

E. For the purpose of meeting the diverse needs and interests of families in the program, family members enrolled in Early Intervention programs may choose to join together in a formal group, called a PAC (Parent Advisory Council), or may be involved in other ways as outlined in the Parent Leadership Project Resources Manual. Those needs and interests might include performing an advisory role with the program, establishing friendships with other families in the program, providing mutual support, facilitating networking, sharing information, and fundraising.

F. If a program has a PAC that chooses to play an advisory role, the program will still ensure that all families regardless of affiliation with the PAC are encouraged to be involved in the advisory activities listed above. If a program does not have a PAC, the program will ensure that families are informed that they have the option to form one. Information and support is available through the Parent Leadership Project (PLP).

G. If a program has a PAC, the program has the responsibility to:

1. Ensure information regarding the PAC's availability and activities is communicated to all enrolled families
2. Encourage activities which are responsive to the cultural and linguistic diversity of the program
3. Invite participation in the advisory functions outlined above.

H. The program provides support and assistance to families for developing and maintaining a PAC, such as:

1. Covering reasonable administrative expenses such as copying and distribution of information to families about the PAC and its activities
2. Copying and postage expenses for a PAC newsletter (if PAC members publish one)
3. Assisting family members to problem solve solutions to barriers to participation
4. Assisting with access to and the use of funds raised by the PAC
5. Designating an EI staff member who will be a link between the staff and the PAC

XI. Health and Safety

A. Health Care Consultant

The Early Intervention program has either a physician or registered nurse with pediatric or family health training and/or experience, as the program's health care consultant. The consultant assists in the development of the program's health care policy and approves and reviews the policy at least every two years. The consultant approves the first aid training for the staff, is available for consultation as needed, and approves any changes in the health care policy.

B. Health Care Policies

The program has written health care policies and procedures that protect the health and welfare of children, staff and families. All staff members are trained in such procedures and families receive copies of appropriate policies and procedures as requested. The written health care policy includes, but is not limited to, the following plans and/or procedures:

1. A plan for the management of infectious diseases. The plan includes:
    a. Criteria regarding signs or symptoms of illness which will determine whether a child, or staff member, will be included or excluded from activities
    b. Policies for when a child or staff member who has been excluded from activities may return
    c. Policies regarding the care of mildly ill children in attendance at a non-home-based activity including special precautions to be required for the following types of infectious diseases: gastro-intestinal, respiratory and skin or direct contact infections, until the child can be taken home or suitably cared for elsewhere
    d. Procedures for notifying parents when any communicable disease, such as measles or salmonella, has been introduced to the group

2. A plan for infection control. Procedures are written to include:
   a. directions for proper hand washing techniques
   b. instructions on the care of toys and equipment
3. A plan for the control of diseases spread by blood products and body fluids. Procedures are written to include:
   a. Universal precautions, including the requirement that staff use single-use latex-safe gloves when they are in contact with bodily fluids and that contaminated materials are cleaned or disposed of properly. (See Appendix C of these standards for Infectious Disease Control and Sanitation Requirements.)
   b. Annual training in blood-borne diseases including hepatitis B, C and HIV
   c. An exposure control plan
   d. Staff are offered a hepatitis B vaccine series at the time of hire
4. A procedure for reporting suspected child abuse or neglect to the Department of Social Services. The procedure includes assurances that:
   a. As mandated reporters all staff will report suspected child abuse or neglect to the Department of Social Services pursuant to M.G.L. c. 119 § 51A, or to the program's director or designee
   b. The program director or designee will immediately report suspected abuse or neglect to the Department of Social Services pursuant to M.G.L. c. 119 § 51A
   c. The program director or designee will notify the Department of Public Health, Early Intervention Services, immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child while in the care of the program or during a program related activity.
   d. The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect that includes but is not limited to ensuring that an allegedly abusive or neglectful staff member does not work directly with children until

the Department of Social Services investigation is completed or for such a time as the Department of Public Health requires.

C. Staff Requirements

1. Within the first six months of hire, all direct care staff obtains and maintains annual certification in CPR that specifically addresses infants and toddlers. The CPR curriculum includes the management of a blocked airway and rescue breathing. Staff must also obtain and maintain certification in pediatric first aid. The curriculum for first aid includes treatment for seizures and burns in addition to basic first aid training.
2. Prior to the initiation of any direct contact with families, new staff, regularly scheduled volunteers and student interns must present to the program director evidence of:
   a. A physical examination within one year prior to employment. The physical examination is valid for two years from the examination date and will be repeated every two years thereafter.
   b. Immunity for measles, mumps, rubella and chicken pox in accordance with MDPH regulations (See Appendix C of these standards.) Such evidence is not required of any person who states in writing that vaccination or immunization conflicts with his/her sincere religious beliefs, or if it is medically contra-indicated.
   c. Negative Mantoux TB test in accordance with current Department of Public Health regulations (See Appendix C of these standards.)
   d. Statement of physical limitations in working with children.
3. A CORI evaluation is completed on, and documented in the personnel file, of each person with the potential for unsupervised contact with children in accordance with current DPH requirements 105 CMR 950.: Criminal Offender Record Information Checks. (See CORI information in the *Massachusetts Early Intervention Services Policy Book*.)

D. Staff Health and Safety

1. The program provides for the reasonable safety of staff while providing services. This may include recommendations to staff regarding phoning families before visits, providing staff in-service training on safety issues.
2. The program provides updated information to staff regarding communicable diseases, preventive health policies, and environmental health risks including second hand smoke.
3. The program provides a copy of the Health and Safety section of these standards at annual staff trainings on health and safety issues.

E. Community Based Program Policies

Early Intervention services, not including those services provided in children's homes, are provided in settings that are safe, that support the optimal development of infants and toddlers, and that are conducive to community collaboration. Such settings are welcoming to young children and their families, and are often part of a naturally occurring family routine. It is critical that settings where young children spend time be carefully evaluated to ensure the health and safety of children, staff, and families participating in EI activities. EI services in community locations generally fall under the following three categories:

1) Lead site: a location where the EI program is primarily responsible for administration of both the program and the physical facility.
2) Shared site: a location where the EI program shares responsibility with a community site for program services, but not for the administration of the physical plant.
3) Participatory site: a location where EI program staff and families join an on-going activity in the community where the EI program does not have responsibility for either the program administration or the physical facility.

All EI programs, regardless of where activities take place, must have the following information readily available:

a. The current DPH Early Intervention program certification and Office of Child Care Services (OCCS) license when appropriate. The program must be licensed by OCCS if it meets the OCCS requirements in Section 102 CMR 7.03. If the program does not meet these requirements and does not have an OCCS license, an Early Intervention Program Facility checklist must be completed by DPH for any site where non-home based services are provided. It is the program's responsibility to notify OCCS in the event their status changes and licensing is required. For a lead site, the Early Intervention Program Facility Checklist must be completed. For a shared or participatory site, the Community Group Facility Approval Form must be completed when caregivers will not be present. (Both forms are found in Appendix C of these standards.)

b. The name, and telephone number of the health care consultant; the telephone number of the fire department, police department, Poison Control Center, ambulance service, nearest emergency health care facility, DPH central and regional offices, telephone number and address of the program, including the location of the program in the facility. This information shall be immediately visible at each telephone.

c. Location of the health care policy and first aid kit.

d. Updated allergy and/or other emergency medical information for each child.

e. Emergency preparedness plan.

f. Evacuation procedures next to each exit.

g. Diapering and toileting procedures.

h. Weekly snack menu. (Not required if provided by individual parent for his/her own child.)

i. Current activity schedule.

j. Behavior management policy.

2. EI staff obtain or have access to information from parents regarding:
    a. The child's daily schedule, developmental history, sleeping and play habits, favorite toys, accustomed mode of reassurance and comfort
    b. Procedures for toilet training of the child, if appropriate
    c. The child's eating schedule and eating preferences, where appropriate, including handling, preparation and feeding for unique dietary needs
3. The program has written procedures in place to be followed by EI staff to communicate with parents on a regular basis.
4. The program has written procedures to be followed in case of illness or emergency. These procedures include method of transportation and notification of parents, as well as procedures when parent(s) cannot be reached. In addition programs shall obtain:
    a. Written parental consents for emergency first aid and transportation to a specific hospital in emergencies
    b. Written parental consent specifying any person authorized to take the child from the program or receive the child at the end of an activity
    c. If parent not present, parental permission must be obtained for child to participate in activities at various community locations (e.g. library, playground)
    d. Additional parental consent for any field trips not on list above
5. The program maintains adequate first aid supplies and has a procedure for the use, storage and transportation of first aid supplies. A portable first aid kit must accompany staff on all non-home based activities. (See Appendix C of these standards for information regarding first aid kits).

6. The program has an injury reporting policy that includes, but is not limited to:

a. An injury report that includes the name of child, date, time and location of accident or injury, description of injury and how it occurred, name(s) of witness(es), name(s) of person(s) who administered first aid or medical care and first aid or medical care required (See sample injury report from OCCS in Appendix C of these standards.)

b. The policy for informing parents, in writing, within 24 hours, of any first aid administered to their child and immediately informs them of any injury or illness that requires care other than first aid

c. The assurance that the injury report shall be maintained in the child's file

d. The maintenance of a central log or file of all injuries which occur during program hours and the policy for periodically monitoring the safety record of the program to identify problem areas

e. The maintenance of daily attendance records which indicate each child's attendance, arrival and departure times to be available to program staff at all times

The following sections apply only when services are being provided in a lead site (as defined under Community Based Program Policies of these standards).

The program has a procedure for the care of mildly ill children at the site. The plan shall include, but not be limited to, meeting individual needs for food, drink, rest, play materials, comfort and appropriate indoor activity.

(1) The program shall provide a quiet area for mildly ill children.

(2) Where mildly ill children are cared for in a separate space or room, the program is permitted to care for mixed age groups of children, provided that the staff ratio for the youngest child in the group is met at all times.

(3) Staff who are assigned to care for mildly ill children in a separate space or room are trained in the following areas:
(a) General practices and procedures for the care and comforting of the mildly ill children
(b) Recognition and documentation of symptoms of illness
(c) Taking children's temperature

f. The program does not permit smoking in the EI site.

g. The program does not permit hot liquids in the presence of children.

h. The program has developed procedures for injury prevention and management of medical emergencies during field trips. The program ensures that a first aid kit and the list of emergency numbers for the children are available on any field trip.

7. The program has a plan for administration of medication. The program may accept written parental authorization for specific non-prescription topical medications to be administered.

a. Topical medications such as petroleum jelly, diaper rash ointments, and anti-bacterial ointments which are applied to wounds, rashes, or broken skin must be stored in the original container, labeled with the child's name, and used only for that individual child.

b. Topical medications such as sunscreen, bug spray, and other ointments which are not applied to open wounds, rashes, or broken skin may be generally administered to children with written parental authorization.

8. The program develops with the family a written medical care plan for meeting individual children's specific health care needs, including the procedure for identifying children with allergies and protecting children from exposure to foods, chemicals, or other materials to which they are allergic. (See sample DPH Individualized Health Care Plan [IHCP] in Appendix C of these standards.)

9. The program has written Preventive Health Care Procedures.

a. The program does not admit a child or staff member who has a diagnosed communicable disease (which cannot be contained by Universal Precautions) during the time when it is communicable. The program notifies all parents and participants when any communicable disease, such as measles, mumps and chicken pox has been introduced to the group.

b. The program monitors the environment daily to immediately remove or repair any hazard that may cause injury.

c. The program keeps all toxic substances, poisonous plants, medications, sharp objects, matches, and other hazardous objects in a secured place out of reach of children.

d. Program health records include each child's annual physical and immunization records. (See DPH sample form in Appendix C of these standards.)

All children enrolled in EI are up to date on immunizations according to the recommendation of the Massachusetts Department of Public Health, unless the child's parent has stated in writing that vaccination or immunization conflicts with his/her sincere religious beliefs or if the child's physician has stated in writing that the vaccination or immunization is medically contraindicated.

(1) The program enrolls a child in Early Intervention only if provided with a written statement from a physician which indicates that the child has had a complete physical examination (which includes screening for lead poisoning) within one year prior to admission, or obtains one within one month of admission or obtains written verification from the child's parent(s) that they object to such an examination on the ground that it conflicts with their sincere religious beliefs.

(2) All children are screened for lead at least once between the ages of nine and twelve months and annually thereafter until the age of thirty-six months. For all children enrolled in Early Intervention prior to nine months of age, a statement signed by a physician that the child has been screened for lead is obtained by the EI program.

10. The program has written procedures for regular toileting and diapering of children and for disposal/cleaning of soiled clothing, diapers and linens. The program maintains at least one toilet and washbasin in one or more well ventilated bathrooms.
    a. When adult toilets and washbasins are used, the program provides non-tippable stairs to permit access by those children who are able to use them.
    b. In addition to toilets, portable "potty chairs" may be used in the bathroom or separate room for children unable to use toilets.
    c. If cloth diapers are used, a flush sink or toilet for rinsing diapers and a hand washing facility is provided convenient to the diaper changing area.
    d. Special handrails or other aids shall be provided if required by special needs children.
    e. The program provides both hot and cold running water in washbasins and for water used by children. There is a temperature control to maintain a hot water temperature at no more than one hundred twenty (120) degrees Fahrenheit.
11. Food provided at the site is nutritionally and developmentally appropriate for children.
    a. The program follows parental or physician's orders in preparation or feeding of special diets to children and follows the directions of the parents in regards to any food allergies of the child or where vitamin supplements are required.

b. The program prepares nutritious and tasteful snacks in a manner that makes them appetizing.

c. The program stores, prepares and serves all food and beverages in a manner that ensures that it is free from spoilage and safe for human consumption. The program provides refrigeration and storage for food at not less than 32°F or more than 45°F for food requiring refrigeration. The program stores all food in clean, covered containers. The program shall dispose of milk, formula or food unfinished by a child.

d. The program provides tables and chairs for use by children while eating which are of a type, size and design appropriate to the ages and needs of the children. When feeding tables or highchairs are used, they are designed to prevent children from falling or slipping. The program washes and disinfects the tables or highchair trays used by the children for eating before and after each meal.

e. The program provides eating and drinking utensils that are appropriate to the age and needs of the children.

(1) Eating and drinking utensils are free from defects, cracks and chips.

(2) Disposable cups and plates may be used, but if plastic silverware is used, it shall be heavy duty and dishwasher safe.

(3) All reusable eating and drinking utensils are thoroughly washed and sanitized before reuse.

f. The program provides a source of sanitary drinking water located in, or are convenient to, rooms occupied by children.

12. Requirements for Pets

The program selects pets for the center that are developmentally appropriate for children. Before children are exposed to any animal, staff shall consider the effect on children's health and safety, with special attention to children with compromised immune systems and other

vulnerabilities. Under no circumstances should children come into contact with reptiles at the EI program. (See Appendix C of these standards for additional information.)

13. Physical Facility:

a. All lead sites must have the following:

(1) A current Building Certificate of Inspection. The Building Certificate of Inspection is signed by the building inspector in conjunction with the local fire inspector, states capacity of children and lists an expiration date. If the program site offers toddler groups (without caregivers present), the Building Certificate of Inspection is specific to those rooms used for services and specifies "Code I-2 Usage" (indicating children under 2.9 years) and "E Usage" (children over 2.9 years) or states "infants and toddlers." The certificate of inspection certifies that the program's site complies with the State Building Code (780 CMR 633.0)

(2) Documentation that the site is lead free.

(a) For a facility built prior to 1978, the program provides evidence of a lead paint inspection from the local board of health, or the Massachusetts Department of Public Health, or a private lead paint inspection service and compliance with 105 CMR 460.000 (Department of Public Health Prevention and Control of Lead Poisoning regulations).

(b) For a facility built after 1978, the program provides documentation of the construction date.

(c) The program removes and covers any chipping, flaking or otherwise loose paint or plaster.

(3) Programs are required to have at least one site that is accessible as defined in the Americans with Disabilities Act (ADA). The site must be accessible in all areas (including bathrooms) to children,

staff and caregivers. If not accessible, an action plan to address the deficiency is filed with the Department of Public Health.

(4) All programs have a policy and procedures for regularly scheduled evacuation drills.

(a) The program holds practice evacuation drills at least every other month, at different times of the group schedule. The program documents the date, time and effectiveness of each drill. The program develops specific procedures to be followed for evacuating children with disabilities, and for infants and toddlers.

(b) Emergency Situations: The program develops specific written contingency plans and procedures to deal with fire, natural disasters, and loss of power, heat, or water.

(5) The program facilities are asbestos safe.

(6) Indoor space meets the following requirements: The program shall have a minimum of 40 square feet of **activity space** per child, exclusive of hallways, lockers, wash and toilet rooms, isolation rooms, kitchens, closets, offices or areas regularly used for other purposes.

(a) Floors of rooms used by children are clean, unslippery, smooth and free from cracks, splinters and sharp or protruding objects and other safety hazards.

(b) Ceilings and walls are maintained in good repair, and are clean and free from sharp or protruding objects and other safety hazards.

(c) All steam and hot water pipes and radiators are protected by permanent screens, guards, insulation or any other suitable device which prevents children from coming in contact with them.

(d) All electrical outlets that are within the reach of children are covered with a safety device when not in use. If the covering is a shock stop, it shall be of adequate size to prevent a choking hazard.

(e) Room temperature in rooms occupied by children are maintained at a draft-free temperature of not less than sixty-five

(65) degrees Fahrenheit at zero degrees temperature outside; and at not more than outside temperature when the outside temperature is above eighty (80) degrees Fahrenheit.

(f) There is designated space, separate from children's play or rest areas, for administrative duties and staff or parent conferences.

(g) There is sufficient space, accessible to children for each child to store clothing and other personal items.

(h) The interior of the building is clean and maintained free from rodents and/or insects. The program employs integrated pest management as necessary, and notifies families in advance of any pest management that is planned.

(i) The program provides suitable guards across the insides of any windows that are accessible to children and present a hazard. The program provides suitable guards across the outside of basement windows abutting outdoor play areas.

(j) Guards are placed at the top and bottom of stairwells opening into areas used by children. Pressure gates may not be used at the top of stairs.

(k) Routine, major housekeeping activities such as vacuuming, washing floors and windows are not be carried on in any room while it is occupied by children.

(l) The program provides a barrier, such as a door or gate, which prevents children's access to the kitchen while unsupervised.

(m) The kitchen is maintained in a sanitary condition and garbage receptacles used in the kitchen are emptied and cleaned daily.

(n) The program maintains eating areas that are sufficiently large to fit tables and seats for children eating in an uncrowded manner, and are clean, well-lit and ventilated.

7. The program maintains, or has access to, an outdoor play area of at least 75 square feet per child using it at any one time, including those with disabilities. The outdoor play area is not a requirement

when children are in attendance at the program site less than 4 hours per day. Outdoor play areas are accessible to young children and to children with disabilities.

(a) The outdoor play area is accessible to both direct sunlight and shade.

(b) The average width of such a play area is not less than eight feet.

(c) The outdoor play area is free from hazards including but not limited to: a busy street, poisonous plants, water hazards, debris, broken glass, and any such hazard is fenced by a sturdy, permanently installed barrier which is at least four feet high or otherwise protected.

(d) If the outdoor play area is located on a roof, it is protected by a non-climbable barrier at least seven feet high.

(e) It is not covered with a dangerously harsh or abrasive material and the ground area under swings, slides climbing equipment, seesaws, etc., is not paved or is covered with mats.

(f) Pea gravel and wood chip nuggets are not used.

(g) The ground area and fall zones under swings, slides, and climbing structures are covered with an adequate depth of an impact absorbing material.

14. Equipment:

a. The program uses only equipment, materials, furnishings, toys and games that are appropriate to the needs and developmental level of the children. They are sound, safely constructed, flame retardant, easily cleaned, and free from lead paint, protruding nails, rust and other hazards that may be dangerous to children.

b. The program keeps all equipment, materials, furnishings, toys and games clean and in safe workable condition. Equipment is sturdy, stable and non-tippable.

c. Some materials and equipment are visible and readily accessible to the children in care and shall be arranged so that children may select, remove and replace the materials either independently or with minimum assistance.

d. The program provides equipment and materials that reflect the racial and ethnic composition of the children enrolled.

XII. Program Administration

A. Early Intervention programs must have a full-time primary program administrator. A primary program administrator may be a Program Director or Program Coordinator and must meet the credentialing requirements for one of the disciplines listed in Section V. of these standards. If the administrative responsibilities are shared within an agency, a written administrative plan is developed, designating specific roles and responsibilities to named individuals. The primary program administrator is required to apply for Early Intervention Program Director Certification within three years of assuming that position.

B. Each Early Intervention program has an organizational plan and written policies addressing processes and procedures that are readily available.

1. A written administrative organizational plan that designates the person/persons responsible for:
    a. Administrative oversight
    b. Program development
    c. Budget development and oversight
    d. Program evaluation
    e. Staff development
    f. Hiring, review and termination of staff
    g. Clinical program supervision
    h. Linkage to vendor agency
    i. Linkage to lead agency
    j. Designation of administrative coverage during hours of operation
    k. Facilitation of family involvement and linkage between staff and parents
    l. Approval and assistance in developing health care policies for the program (either a physician or registered nurse)
    m. Coordination of transportation issues and the processing of transportation forms and reports

2. Policies addressing staff rights and responsibilities including:
    a. Salary
    b. Basis for evaluating performance
    c. Benefits
    d. Scheduled holidays/vacations
    e. Conditions for immediate discharge
    f. Grievance procedure
    g. Resignation procedure
    h. Job responsibilities as per individual program job description or contractual arrangements
    i. Professional development
    j. Program hours of operation
3. Personnel records for each staff member, which includes but are not limited to:
    a. Employee's resume or job application
    b. Documentation that the employee has met the credentialing requirements
    c. Record of reference verification
    d. Documentation of completed CORI evaluation
    e. Health records as required in Section XI, C of these standards
    f. Documentation of training required to meet core competencies
    g. Annual performance evaluations
    h. Documentation of EI certification status
4. The following written procedures are available to any interested party on request:
    a. Referral
    b. Screening
    c. Determination of eligibility (evaluation)
    d. Assessment
    e. IFSP development
    f. Service delivery modes

g. Transition

h. Discharge

i. Maintenance, management and preservation of client records in accordance with the due process procedures found in Appendix D of these standards.

j. Release of record with written parental consent

k. Guidelines for referral to specialty providers and services

5. The record kept on each individual child contains the following:

a. Access sheet for recording those authorized persons who have reviewed a record

b. Signed parental consent forms

c. Documentation of referral

d. Completed DPH EIIS (Early Intervention Information System) Forms – Referral, Evaluation, IFSP, Discharge

e. Intake and background information

f. Medical information

g. Reports from other agencies and professionals, as applicable

h. Results of evaluations and assessments

i. IFSPs

j. Documentation of contacts with child and family including date, service type, duration and content of contact, and the legible signature and discipline of the staff person signing the note

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C. Program staff members are available by phone during regular business hours. Telephone answering machines or voice mail do not satisfy this requirement.

D. Early Intervention programs are grounded in child development and serve young children and their families within the context of understanding the full spectrum of child development. Therefore the Developmental Specialist serves a critical function within the EI core team. Early Intervention programs must employ at least one Developmental Specialist (a, b or c) [who works at least 30 hours per

week] for the first 75 enrolled children. After the first 75 enrolled children, Developmental Specialist hours may be a combination of part-time staff.

Ratios must comply with the following:

- for 1 – 75 enrolled children, one 30-hour per week Developmental Specialist (a, b or c)
- for 76 – 150 enrolled children, an **additional** 30 hours weekly of Developmental Specialist (a, b or c) time
- for 151 – 225 enrolled children, an **additional** 60 hours weekly of Developmental Specialist (a, b or c) time
- etc.

E. Early Intervention programs are expected to comply with the submission of data requested by the Department of Public Health within the timelines established. Timelines for Early Intervention EIIS Forms:

1. Referral Form – within 10 days of referral
2. Evaluation Form – within 10 days of a completed evaluation
3. IFSP Form – within 10 days of IFSP signature
4. Discharge Form –
    a. Client screened out, client screened in but family declines evaluation, client screened in but program loses contact with family following the screening – Discharge Form – within 10 days of inactive date or date of screening.
    b. Client has received a completed evaluation but family declines services or program loses contact with family – Discharge Form within 10 days of inactive date or date of evaluation.
    c. Client has an IFSP - 10 days after the inactive date or last date of active service. (Eligible children may receive services up to but not on their third birthday).

Please note – a transition visit (as defined in Section IX, B of these standards) may occur after the submission of the Discharge Form.

F. Each program conducts an annual self-evaluation. Programs encourage families to participate in this self-evaluation that should include areas such as:

1. Feedback on staff performance
2. Evaluation of program services
3. Review of IFSP process
4. Review of transition procedures
5. Approaches to family participation
6. Review of health and safety procedures
7. Review of interagency agreements and service contracts

G. Each program develops a written procedure for the internal resolution of complaints. Any family with a complaint must be informed again (as they were at intake, see Section VI.C.3) of procedural safeguards and family rights. Families must also be informed of their option to speak to Department of Public Health personnel and/or file a formal written complaint. At the time of the family's complaint, a copy of the Family Rights and Early Intervention Services brochure is given to the family. Due process procedures for families enrolled in Early Intervention are outlined in Appendix D of these standards

H. 1. Department of Public Health policies call for the collection of an Annual Cost Participation Fee. The fee is required for all children with a signed IFSP whose family annual income is equal to or greater than 200% of the published Federal Poverty Income Guidelines (FPIG). Families whose income is 200% - 400% pay an annual fee of $25 ($20 for the 2nd child with a maximum contribution per family of $45) while a family whose income is greater than 400% pays an annual fee of $50 ($50 for the second child for a maximum contribution per family of $100). This fee is applicable to all services with the exception of those services that are exempt from charge per IDEA Secs. 303.520 and 303.521.

2. The services to be rendered and the corresponding costs for such services are referenced in the Department of Public Health Early Intervention Billing Instructions and payable according to the rate structure defined by the Massachusetts Division of Health Care Finance and Policy (formerly known as the Massachusetts Rate Setting Commission.) Services, as appropriate, may be billed to the Department of Public Health, the Division of Medical Assistance, and other third party payers.

3. Each program must assure that no fees are charged for the services that a child is otherwise entitled to receive at no cost to parents. Programs must also assure that the inability of parents of an eligible child to pay for services will not result in the denial of services to the child or the child's family.

4. Each program must assure that services will not be delayed or denied to any child because of disputes between agencies regarding financial or other responsibilities.

2. Fees

The Department of Public Health hereby assures that the following services will be carried out at public expense and for which there will be no fees charged to parents:

a. Implementing the child find requirements in Sec. 303.321.
b. Evaluation and assessment, as included in Sec. 303.322, and including the functions related to evaluation and assessment in Sec. 303.12.
c. Service coordination, as included in Secs. 303.22 and 303.344(g).
d. Administrative and coordinating activities related to:

- The development, review, and evaluation of IFSPs in Secs. 303.340 through 303.346; and

Implementation of the procedural safeguards in subpart E of this part and the other components of the statewide system of early intervention services in subparts D and F of this part.

XIII. Request for Waiver

A. Request for waiver from these standards may be made by submitting a written request to Early Intervention Services, Massachusetts Department of Public Health. (See sample Waiver Request Form in the *Massachusetts Early Intervention Services Policy Book*.)

B. The Massachusetts Department of Public Health retains authority to allow or deny the request.